Patient Health Information

Welcome to our Chiropractic office. Please help us serve you better by completing this patient information sheet as fully as possible. It is our pleasure to serve you!

Personal Information:

Name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip Code: _____ Birthday: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email: _____ Referred by: _____
SS#: _____ Marital Status: _____ # of Children: _____
Employer: _____ Type of Work: _____

Health Information:

What is the purpose of this visit? _____
How would you rate your health? Excellent Good Average Poor Very Poor
Do you have any of the following?

___ Neck Pain	___ Low Back Problems	___ Sinus Problems	___ Anemia
___ Dizziness	___Heart Problems	___ Strokes	___ Diabetes
___ Headaches	___ Digestive Problems	___ Numbness	___Asthma
___ Allergies	___ Alcohol/ Drug Abuse	___ Arthritis	___ Cancer

Please list any and all medications that you are taking: _____
_____
Are you doing/ using any of the following?

___ Smoking	___ Exercise Program	___ Nutritional Program
___ Acupuncture	___ Massage Therapy	___ Psychotherapy
___ Drugs/ Alcohol	___ Physical Therapy	___ Orthotics(Foot Inserts)

Have you had any surgeries in the last 5 years? If yes, please list: _____
_____

Insurance/ Billing Information:

Name of Insured: _____ Relation to Insured: _____
Insurance Company: _____ Policy#: _____
Address: _____ Phone: _____

I understand and agree that health and accident insurance policies are an arrangement between me and an insurance carrier. I also understand and agree that any services rendered to me and any charges billed to me are my personal responsibility. If I suspend or terminate my care, all services rendered to me will be immediately due and payable.

Patient Signature: _____ Date: _____
Parent/ Guardian Signature: _____ Date: _____

Initial Consultation Form

Patient's Name: _____ Date: _____

Primary Complaints: _____

_____

_____

Please describe your condition when it is at its worst: _____

_____

_____

Please circle the appropriate responses:

Frequency of complaint: (% of the time you have pain)

Constant (100%) Frequent (75%) Intermittent (50%) Occasional (25%)

Intensity of the complaint: (How much it bothers you)

Severe Moderate Slight Minimal

Quality of the complaint: (Describe how it feels)

Sharp Achy Numbness Tingling

How would you rate your commitment to getting the problem fixed?

Fully committed Moderately committed Mildly committed

What type of care are you looking for?

____ Relief Care (Patch the problem to get rid of symptoms)

____ Corrective Care (Correcting the problem that is causing the symptoms)

____ Comprehensive Care (Not only correcting the problem, but attaining the highest possible health through Chiropractic Care)

Is your problem affecting other areas of your body? If yes, please explain: _____

_____

What aggravates the problem? _____

What relieves the pain? _____

What have you tried to help fix the problem? _____

How does the problem interfere with your life? (Work, hobbies, family, etc.) _____

_____

Is the problem getting worse? Please explain: _____

If you have any other questions or concerns please list here: _____

_____

Signature: _____ Date: _____

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do no offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our method is specific adjusting to correct vertebral subluxations.

I, _____, have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

Informed Consent for Chiropractic Treatment of your Pain

The nature of chiropractic treatment:

The doctor will use his/her hands or a mechanical device to manipulate the area treated. You may feel or hear a "click" or "pop" and you may feel movement. Chiropractic treatment also includes activity advice, exercise, hot or cold packs, laser treatment, or electric stimulation. Your chiropractor will recommend treatment he/she determines is most appropriate for your condition.

Possible risks:

Chiropractic treatment for pain is safe and the majority of patients experience decreases in pain and improved mobility. Approximately 30% of patients experience slight increased pain in the treatment area, possibly due to minor strain of muscle, tendon, or ligament. When this occurs within the first few days of treatment, the increased pain is brief and returns to baseline or improves over the next few days. Increased pain may also occur with exercise, heat, cold, laser treatment, and electrical stimulation. Possible skin irritation or burns may occur with thermal, laser or electrical therapy. Serious bodily harm is extremely rare and not an inherent risk of chiropractic treatment. Many variables can adversely affect one's health, including previous injury, medications, osteoporosis, cancer and other illness, disease or condition. When these conditions are present, chiropractic treatment may be associated with serious adverse events, such as fracture, dislocation, or aggravation of previous injury to ligaments, intervertebral discs, nerves, or spinal cord. Symptoms of stroke or cerebrovascular injury alert patients to seek medical and/or chiropractic care. Your chiropractor is aware of this association and when appropriate may assess for symptoms and signs of stroke. *Please inform your chiropractor of all medications you are taking, including blood thinners, any surgeries you have had and any other medical condition you have had, including osteoporosis, heart disease, cancer, stroke, fracture or previous severe injury.*

Other options for the treatment of pain include:

Do nothing or live with the pain, over the counter medications, physical therapy, medical care, injections, or surgery. There are hundreds of other treatments for pain. Most treatments that have potential benefit also have potential risk. You are encouraged to ask questions regarding the possible risks of chiropractic treatment, and you may use the space below for this purpose.

_____

My signature below confirms that I have read the paragraphs above and that I understand what my chiropractor has told me about possible risks of chiropractic treatment and that I have had the opportunity to ask questions and have my questions answered. Also, I have fully disclosed to my chiropractor my medical history regarding the above specified complicating factors and all other conditions that have caused me pain in the past.

_____	_____	_____
Printed Name	Signature	Date

Lighthouse Chiropractic Health and Wellness Center

Attention all Patients:

Re: New HIPPA Guidelines
The Chiropractic Health Centre
January 1st, 2003

Dear Patient,

As of January 1st, 2003 (enforceable April 14th, 2003) the federal government announced new security rules and regulations, called the HIPPA accords. These new guidelines were passed to protect the public from identity theft and to keep medical records secure. Although most of the regulations are in regard to Internet connected computer files, there are some parts of the new regulations that affect our office and more directly, affect you.

Our current office procedures keep files extremely safe, and no information about you or your case is ever shared with any outside sources without your consent. However, some of our office procedures exhibit patient names or pictures to other patients. These office procedures may not be in line with the new HIPPA guidelines.

The procedures are:

'Welcome New Patient' names are written in the reception room.
X-rays and EMGs may be found in the examination room. (Not guarded)
Patients may discuss personal information in the open adjusting room.
Patient files (Hard copies and Computer files) are not kept locked.
Pictures of Patients may be viewed in the reception room.
Testimonials, written by patients, may be found throughout the office.
Occasional mail may be sent to patients. (Approximately 3 times per year)

In an attempt to keep in line with the various federal regulations, we are asking patients to sign this form indicating if they consent to their name or picture being exhibited in the office. By signing the "I Consent" line below, you understand and are not in disagreement with the procedures listed above. (You do not mind if people see your name or picture) Patients who do not agree with any of the procedures listed above, or who prefer to have their name/records under additional security, should sign the "I Do Not Consent" line below.

If you have any questions regarding these procedures, or regarding the signing of this form, please ask any of the employees of the Chiropractic Health Centre.

I Do Consent to the aforementioned procedures:
Printed name: _____ Date: _____

I Do <u>Not</u> Consent to the aforementioned procedures:
Printed name: _____ Date: _____

Witnessed by a CHC Staff Member: _____ Date: _____